

# STATE BOARD OF HEALTH COMMENT ON DSHS/MAA “GUIDING THEMES” FOR STRATEGIC PLANNING

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The State Board of Health appreciates the special effort MAA extended to solicit our comments on your strategic plan. We think it is important to provide a detailed response. While many local public health jurisdictions receive funding from MAA, we believe public health is not just one of MAA’s many special interest provider constituencies. Public health is an intellectual discipline and approach to setting public spending priorities that holds great value in contributing to Medicaid’s thinking about funding and system development.

## **MAA’s Guiding Themes in Strategic Planning:**

- 1. Improve our citizens’ health by purchasing evidence-based health services.**
- 2. Allocate and maximize resources to achieve fiscal efficiency.**
- 3. Integrate service delivery to improve access and service quality.**

We are encouraged to see the first of MAA’s Guiding Themes. We believe this ought to be all state health purchasing agency’s primary goal, including Medicaid’s. We recognize however, that Medicaid has a more specific target—our state’s low-income and disabled persons. It also has a more narrow, federally imposed priority—needed medical treatments once a health condition has been diagnosed. We nonetheless believe that if Medicaid were to make health status improvement its primary goal, it might see many opportunities for improvements in value and efficiency it now overlooks.

We share Governor Locke’s, Secretary Braddock’s, and Secretary Selecky’s views that government’s first and best investments in health improvement—including for low income and chronically ill persons—are public health investments. That means government should assure a robust disease surveillance system and rapid emergency response capacity, community assessment of reliable data on patterns of illness and health risk, health education, community and policy level mobilization to promote social and environmental conditions that reduce health risks and promote healthy behavior, and universal access to proven personal health interventions most likely to catch illness or injury early, treat it quickly or manage it effectively if it is chronic.

We believe Medicaid’s role should be to see that this mix of services is provided to the poor and chronically disabled among us. Medicaid should be a partner in funding targeted disease surveillance, targeted social and physical environmental health interventions, and targeted disease prevention interventions for the poor and disabled. If it is a priority of government to provide a public health infrastructure for the entire population, it follows that this infrastructure should address the poor and disabled, as that is where the bulk of society’s illness burden is borne.

In addition, we believe it is a central priority of government to provide adequate subsidies to assure receipt of proven clinical preventive, medical, and chronic care support for all of those of modest means. No one else will do it, and the job flows directly from our state Constitution’s mandate to provide for public welfare. That is why cutting Medicaid enrollment should never be an option. It systematically denies the poor, who experience a

disproportionate burden of disease, of any needed health services, effective or not. That makes cutting Medicaid enrollment the greatest imaginable violation of the theme of using evidence-based medicine to improve health status. It is contrary to government's core responsibilities and is counterproductive as a cost saving strategy. Costs are not "saved," they are just shifted to other parts of the system. Ultimately, the failure to use evidence-based prevention and early treatment strategies dramatically increases costs—displacing low cost primary care with high cost "rescue therapies" and hospital-based care.

One way to reduce the need to consider cutting Medicaid enrollment is to "*allocate and maximize resources to achieve fiscal efficiency.*" We support the second of MAA's Guiding Themes to that extent, and to the extent efficient public programs free funds to make additional health program improvements. However, efficiency is just budget cutting without a clear goal toward which efforts are to be directed. So in this response, we assumed the goal is improved health status, as stated in MAA's first Guiding Theme. If MAA were to eliminate waste on needlessly complex administration, on ineffective services, and on heroic but futile medical interventions at the end of life, additional funds should be available to pursue greater health status improvement, including maintaining or increasing enrollment.

We will not dwell here on the complexity of current health administrative structures in both the public and private sectors. We will say only that among the most politically difficult but patient-friendly improvements MAA might make in the name of "fiscal efficiency" is administrative simplification. While we recognize that each separate program, each data point and each administrative process has its purpose, or at least did at one time, still we all know that consolidating and becoming more transparent about our goals can create the environment for simpler accountability. We know this is an ongoing process and so we offer only the following illusive goal: eliminate as many intermediaries as possible, both public and private, between the source of payment and the point of service delivery. Each one remaining should demonstrate a clear, current value added.

In the search for greater efficiency and effectiveness among Medicaid's current benefits package, we view Secretary Braddock's efforts to begin adopting proven disease management strategies and to begin integrating chronic care programs more completely with medical interventions as steps in the right direction. We think the health status improvement these integration efforts promise warrants their support and enhancement into DSHS's way of doing business, even at the risk of offending entrenched special provider groups or uninformed consumer groups who might oppose such moves. While many such efforts have documented significant cost savings, we do not think that cost savings alone should be the criteria for implementing these changes. Improved value: outcomes per cost should be.

One of several places where this strategy might not save costs, but might improve health status and so should be pursued is the medical service infrastructure for those with developmental disabilities. We hope Medicaid will make an early priority of applying these value-improving strategies to this alarmingly inadequate medical services infrastructure, particularly for the vast majority who live in the community.

Another too often overlooked set of investments to improve the health value and "*fiscal efficiency*" of Medicaid purchasing is the relatively cheap, proven array of clinical preventive services and supports for healthy living now available. We know that some of these services

are "optional" in Medicaid's bewildering federal parlance. But it is long overdue for the state to make universal receipt of, not just payment for, EPSDT services a standard for all Medicaid kids. MAA could, for example, provide financial incentives to families to use the services, if that's what it takes.

We will not improve the "fiscal efficiency," health status, or value of public purchasing in health services by simply offering clinical preventive services, or even just by providing some funds to offset their cost for providers, but failing to remove other barriers. If patient and provider education is necessary, let's do it. If better data systems are needed, let's build them. If we must begin considering clearer public health accountability for Medicaid's investments in school health interventions, then we must.

Similarly, the U.S. Clinical Preventive Services Task Force and other groups used the best evidence to identify proven clinical preventive services not just for children, but also for adults through their life span. Their receipt ought to be an early test of MAA's "walking the talk" of "purchasing evidence-based health services to improve citizen's health." Once again, cost reduction should not be the solitary goal; improved value should. So whether increased prevention saves money or simply invests available resources toward better outcomes, it is worth pursuing.

Other medical and social support also merit greater attention. MAA should explore the collaboration that has developed between public health and aging experts in this area, widely known as "Healthy Aging." MAA, or at the very least DSHS, should find ways to support and strengthen this collaboration and to support the community network of social and health support agencies eager to carry this work forward. To the extent that MAA's long-term strategic plan does not make receipt of proven clinical preventive and social support services that improve health status for all segments of the population its priority, MAA will not remain true to its Guiding Themes of improving health status and maximizing fiscal efficiencies.

Other ripe opportunities for moving closer to the use of evidence to improve "fiscal efficiency" in Medicaid purchasing are substance abuse and mental health treatments. DSHS researchers have completed a series of carefully done studies documenting net cost savings of some \$252/month for each SSI Medicaid client enrolled in needed substance abuse treatment. To its credit the Division of Alcohol and Substance Abuse (DASA) and others in DSHS made sure these results and others like them were seen for the cost saving public health improvement opportunities they offered. Similar work has recently been completed showing similar, if somewhat less dramatic financial and health status improvements from providing needed mental health treatment. We are pleased that DSHS used the substance abuse research to justify some improvements in access to substance abuse treatment. However, according to DASA's recently released annual report, some 1,000 people (including 250 children) still languish for 2 to 4 months in DSHS's substance abuse treatment waiting lines. We call on MAA and DSHS to advocate for alcohol and substance abuse caseloads to be tracked by the state Revenue and Caseload Forecasting Council, just as other key social service caseloads have been for years. This will drive us to achieve all of the savings available from timely substance abuse treatment. We see no health justification and no cost justification for substance abuse treatment waiting lines.

A far more troublesome circumstance, especially in light of the recent mental health cost offset research, is that to our statewide shame, the King County Jail remains our state's largest mental health "treatment facility." Since Medicare and Medicaid categorically exclude jail inmates from coverage, use of county jails as mental health treatment facilities constitutes a de facto shift of funding responsibility from state to local government.

As regards other community mental health programs, despite no clear state health policy requiring means testing for mental health programs, some budget writers' zeal to capture federal Medicaid matching funds seems to have resulted in local officials reporting that only suicide attempts or violent acts by the mentally ill against people or property "qualify" for mental health services if the afflicted are not already financially destitute. Like so many other important public health policy decisions in recent years, this one is often presented as an example of fiscal responsibility. We look to DSHS to join us in pointing out that this development may represent fiscal responsibility in some quarters, but in the realm of health value purchasing, it is a blow against fiscal efficiency. DSHS's own recent studies documenting medical cost offsets from providing needed mental health treatment to many Medicaid clients bear this out. See for example <http://www1.dshs.wa.gov/rda/research/3/29.shtm>

Pharmaceuticals to treat mental disorders are the largest single category of drugs purchased in our state's much publicized prescription drug crisis, a strong indicator of the magnitude of severe mental illness in Washington State. As the above cited study finds, anti-psychotic medications are important tools in the management of severe mental illness but are most effective when used in a coordinated system of mental health treatment, crisis intervention, and community support services.

The progressive unraveling of community-based mental health care systems across the state in recent years (coupled with dramatic reductions in state mental health hospital beds) leaves little option for severe mental illness other than drugs or jails. DSHS should consider the evidence its own research department and others have generated that supports making mental health treatment parity inside Medicaid among its primary strategies to improve health status.

A mental health system designed and funded to achieve defined outcomes (e.g. reduced jail time, appropriate use of pharmaceuticals, crisis prevention, improved functional status) would look very different than our current system, which seems more focused on chemical restraints, cost shifting from state to local governments, and inappropriate use of the criminal justice system to deal with those with severe mental illness.

We understand that some of these changes are unlikely in the face of current public perceptions and consumer demands for "the latest magic bullet" and in the face of relentlessly well-financed lobbying efforts of medical service providers and drug and equipment supplier "special interests." That's why it is so important for state government to "get in the game" of marketing safe, economical, and effective health interventions.

The current public/private partnership between the state and some health plans regarding antibiotic resistance and the state's tobacco control initiative have proven that even modest investments in social marketing can affect consumer and provider demand. Why not make

similar commitments to educate consumers and providers in ways likely to reshape demand to evidenced based health services?

#### **4. Sufficiently invest in our human resources to ensure a competent, credible and creative workforce for the future.**

Our consideration of health workforce issues in recent years has viewed the growing shortage of public health professionals, nurses, many types of providers in rural areas and more as a difficult backdrop for a more challenging public health issue. That is the disturbing lack of adequate racial and ethnic diversity among our health professionals. Failure to provide it is documented to contribute to health disparities by reducing access to needed services and by creating a cultural gap between those devising health interventions and those using them.

Greater diversity is absolutely critical in tomorrow's health workforce if we are to understand and respond to the growing diversity in our state's population. By 2010, almost one in five Washington residents will have family roots to places other than Europe. Hispanics, Africans, American Natives, Asians and others are not only growing as a proportion of our population, they bear the greatest burden of many common diseases among us.

When the Board completed its first round of systematic review of this subject, ([http://www.doh.wa.gov/sboh/Priorities/disparities/2001\\_HD\\_Report.pdf](http://www.doh.wa.gov/sboh/Priorities/disparities/2001_HD_Report.pdf)) we approved a recommendation to DSHS regarding its support for medical education that bears repeating here:

*Create a Graduate Medical Education (GME) incentive pool "... the Department of Social and Health Services (DSHS) [should] set aside a portion of the total Graduate Medical Education funds to create a GME Incentive Pool that can be leveraged to help diversify our health-care workforce. The DSHS should encourage hospitals seeking GME funds to recruit under-represented minority residents or direct these funds in other ways, as outlined in this report, to bolster healthcare workforce diversity.*

We restate that recommendation here. Despite our successful efforts to bring the need for greater diversity in our health care workforce to the attention of those more directly addressing health workforce credentialing, training and recruitment issues, much remains to be done. We are still identifying far too few high school students interested in and able to pursue health careers. We still need to see more enter and complete college. We still need to promote better career ladders and lateral moves across the health professions, and we need to train and graduate more racial and ethnic minorities from health professional schools. A more diverse health care workforce will benefit no client group more than those whose health services are financed by MAA. There is no clearer evidence for health outcomes improvement through diversity of the workforce than among MAA clients. And there is no more direct means of assuring that diversity for MAA than to implement the recommendation above.

#### **5. Align our actions with community partners and health providers**

The State Board of Health strongly supports this as a needed Guiding Theme for MAA. We have two observations. The first is that a similar theme appears an important element in the

success of our state's public health system. The second is, perhaps not surprisingly as the state's largest single payer for health services, MAA has a lot of room to improve in this area.

Despite its many shortcomings, Washington's public health system is widely regarded as being among the nation's highest quality, most efficient and most effective. Much of its innovation has "bubbled up" to become statewide practice from local health jurisdictions. Many of those who work in the system credit that not just to the energy and creativity of local health jurisdiction professionals, but also to the atmosphere of respect at the state level for local differences, the flexibility of statewide administrative strategies and the willingness at the state level to support local initiative. At the local level, health jurisdictions achieve similarly positive results by engaging local community partners --- both public and private --- in many aspects of their work. In these state/local and local community partnerships, funding and accountability issues are seen as shared challenges, not win/lose battles.

In contrast, MAA is too often perceived as an Olympia-based, command and control bureaucracy with an organizational culture that seeks to emulate private insurance companies. We believe MAA should seek to become a decentralized, community-supporting agency that works flexibly with its contractors as partners who it respects as peers and experts in their fields.

MAA has complex and often very contentious financial and legal relationships with thousands of individuals and organizations. So its easy to imagine how naïve it may seem to suggest that MAA should do more to partner and respect its contractors and sub agents. But we think this may hold the greatest promise for MAA's success in achieving its goal of improving health status. Our experience is that community health is a widely shared, but diversely approached goal. There can be no doubt that differences with MAA accountability standards can be borne of a desire to defraud. But they can also be borne of legitimate professional differences in conceptions of illness, health or the likely effectiveness of certain programs or policies. Emulation of the private insurance model of health care financing, with its relentless focus on units of service, claims denial, and contested eligibility criteria, should be abandoned by MAA as strategy for achieving community health improvement. Organizational processes and relationships that balance the need for accountability standards with the goal of encouraging innovative community-based partnerships to improve access to and quality of health care services can not only improve relations, but also improve our collective efforts to use the taxpayers' dollar as efficiently as possible to improve health.